BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: ALYSON G., Claimant, vs. ALTA CALIFORNIA REGIONAL CENTER, Service Agency.	OAH No. 2010110290

DECISION

Administrative Law Judge Marilyn A. Woollard, Office of Administrative Hearings (OAH), State of California, heard this matter in Sacramento, California, on November 29, 2011.

Claimant Alyson G. was represented by her mother (mother or Ms. G). Also present on claimant's behalf was Eva Vereschagin, from Colusa County Behavioral Health.

The Service Agency Alta California Regional Center (ACRC) was represented by Legal Services Specialist Robin M. Black, M.A. Also present on ACRC's behalf was Phyllis Magnani, Staff Psychologist.

Oral and documentary evidence was received and the parties offered oral closing arguments. The record closed and the matter was submitted for decision on November 29, 2011.

ISSUE

Is claimant eligible for regional center services based upon a "developmental disability" as defined by the Lanterman Act, Welfare and Institutions Code section 4500 et seq. and California Code of Regulations, title 17(17 CCR), sections 54000 and 54001?[1]

[1] Unless otherwise specified, all statutory references are to the Welfare and Institutions Code.

FACTUAL FINDINGS

1. Claimant was referred to ACRC by her doctors, Dr. Brown and Dr. Hendren, for suspected diagnoses of autism and borderline intellectual functioning. On July 20, 2010, initial intake information indicated that the 11-year-old claimant had been diagnosed with tuberous sclerosis complex, had a history of seizures, and had issues with comprehension. Her doctors believed she had "autism, possibly high functioning." Claimant was about to begin seventh grade, but was described as being delayed by several years and having very slow processing skills. Claimant was also reported to enjoy doing some of the same activities repetitively, and to have difficulties with certain life skills (brushing hair, tying shoes) and transitions.

2. Sue Wheelwright is an intake counselor with ACRA, and a licensed clinical social worker (LCSW). As part of claimant's assessment, Ms. Wheelwright obtained pertinent medical and educational records, interviewed claimant and her family, and wrote a social assessment indicating that claimant "appears to have handicapping conditions in the areas of communication, self-care, self-direction, and capacity for independent living." She recommended that claimant be referred for psychological evaluation to further assess her eligibility.

3. On August 28, 2010, at ACRC's request, licensed clinical psychologist Monica Silva, Ph.D., performed a psychological evaluation of claimant's cognitive, adaptive and behavior skills in order to determine her eligibility. Based on this evaluation, Dr. Silva determined that claimant did not meet the diagnostic criteria for autistic disorder established by the Diagnostic and Statistical Manual, Fourth Edition - Textual Revision (DSM-IV –TR), and that her cognitive abilities were in the average to low-average range. Dr. Silva gave claimant the following Axis I diagnoses: Rule Out Learning Disorder – Not Otherwise Specified (NOS), and Rule out Mood Disorder, NOS.

4. On September 27, 2010, ACRC's interdisciplinary eligibility team met and reviewed the following documents regarding claimant's potential eligibility: Ms. Wheelwright's social assessment; Dr. Silva's psychological evaluation; claimant's medical records from her primary care physician, Dr. Romie Holland; medical records and reports from Dr. Candida Brown, M.D., Director of Oakland Children's Hospital's Tuberous Sclerosis clinic; an August 4, 2009 report from Dr. Robert Hendren; and documents relating to claimant's special education program, including her December 14, 2009 Individualized Education Program (IEP), related speech and language and occupational therapy evaluations, and a student health update.

As indicated in the Notice of Proposed Action (NOPA) dated October 1, 2010, and in ACRC's October 4, 2010 letter to claimant's mother, the eligibility team determined that claimant is not eligible for regional center services because "she does not have autism, epilepsy, cerebral palsy, or mental retardation, or a condition similar to mental retardation, or requiring treatment similar to that required by individuals with mental retardation. [Claimant] does not have a developmental disability that constitutes a substantial disability."

5. On October 18, 2010, claimant's mother signed a Fair Hearing Request challenging ACRC's decision. Ms. G. requested that the two reports provided from claimant's doctors "should be accepted" and that she should not be penalized "because her parents and docs [sic] have worked hard to help her improve."

6. The matter was set for hearing by OAH and was continued on several occasions. Claimant's parent signed a time waiver for holding a hearing under the Lanterman Act.

7. At hearing, claimant's mother provided ACRC with a September 13, 2011 Neuropsychological Evaluation authored by Nicolle Ionascu, Psy. D. This evaluation had not been provided to or considered by the eligibility team.

Claimant's History and Evaluations

8. Tuberous Sclerosis (TS) is a genetic disorder that affects the skin, brain, nervous system, kidneys and heart, and can cause tumors to grow in the brain and other organs. While the tumors are frequently benign, they are hard masses that, in the brain, can cause cognitive problems. TS can be diagnosed from genetic testing. MRI brain scans are used to determine whether tumors are present in the brain and renal ultrasounds are used to assess the kidneys. Claimant's father has TS, as do several other paternal relatives. Based on claimant's family history, Dr. Holland referred her to the Tuberous Sclerosis Clinic, Department of Neurology, at Children's Hospital in Oakland.

9. On July 18, 2006, claimant was assessed by Dr. Brown at the TS Clinic at Children's Hospital. At the time, claimant was 7 years old. Dr. Brown noted that claimant "has TS complex and refractory complex partial seizures."[2] Claimant had last been seen at the clinic on November 15, 2005. Since that time, it was reported that claimant experienced breakthrough seizures at the rate of several per day. Dr. Brown reported that claimant had initially been tried on Tegretol for seizure control. She was switched to Trileptal, but experienced difficulty with mood stabilization; as a result, she was switched back to Tegretol. Claimant still experienced breakthrough seizures that occurred several times a day. Her seizures were not 'tonic-clonic' [i.e., grand mal], but usually occurred when she was falling asleep. Claimant's seizures were "described as right arm or leg jerking with head jerking lasting less than 30 seconds but will often occur in clusters. These can occur anywhere from 0 up to 10-5 times a day, and usually she has these every day. There has been a slight improvement since increasing the Tegretol. There is also concern that she may have absence seizures while awake."

Claimant was also reported to have behavior difficulties, with "frequent meltdowns," where she gets irritable and starts to "smart-mouth." During these episodes, claimant was described as becoming agitated then irritable, aggressive, crying and unable to control herself.

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[2] Refractory complex partial seizures, also referred to as intractable seizures, are seizures that are not controlled by medications.

These episodes lasted from minutes to several hours. Claimant's mother reported that claimant's behaviors seemed to get "out of control" when she had seizures. Claimant's mood was much better since starting Tegretol.

Dr. Brown characterized claimant as alert, pleasant, articulate and cooperative. Her neurological examination was "completely normal." Dr. Brown's impression was that, although claimant had a strong family history of TS, her "testing has remained completely negative to date including head MRI scan, a renal ultrasound and cardiac examination. The diagnosis of tuberous sclerosis remains in question." Because claimant's TSC gene testing found a mutation on the gene for TS, another referral for further analysis was appropriate. Dr. Brown also indicated that epilepsy surgery was being considered. Dr. Brown prescribed Lamictal, in addition to the Tegretol, for seizures and for its mood-stabilizing effects.

10. On September 28, 2006, Kristin Gross, Ph.D., a pediatric neuropsychologist at Children's Hospital, evaluated claimant and performed educational testing. At the time, claimant was receiving accommodations at her school but was not in special education. Claimant had just turned eight years old. She had difficult engaging in intelligence testing. As a result, Dr. Gross was unable to fully assess claimant's intellectual potential. Dr. Gross summarized that:

> [Claimant] currently presents with great cognitive challenges that are intertwined with emotional/cognitive overwhelm and behavioral disregulation. She appears to have specific deficits in processing and mediating verbal information, think abstractly and conceptualize higher order cognitive problems. She appears more comfortable when having to rely on visual processes, however, she becomes quickly overwhelmed by too much information and appears to have no systematic way of approaching more complex or demanding problem-solving tasks in a methodical manner…

Dr. Gross found claimant to have significant deficits in accessing previously learned information; while she learned new information, she had great difficult in freely recalling it. "In contrast, she does perfectly when given recognition clues, options from which to simply choose as opposed to independently recalling specific materials . . ." Dr. Gross offered educational recommendations addressed to claimant's learning, attention and behavior.

11. On January 11, 2007, claimant became eligible for special education and related services through Colusa County, where she attended elementary school. Although claimant's original IEP for special education was not in the records, her triennial evaluation dated December 14, 2009, indicates that claimant was determined to be eligible under the "Other Health Impairment" category. It also provided claimant's history of academic and intelligence testing: In April 2005, claimant received a full scale average range score of 88-96 on the Wechsler Intelligence Scale for Children (WISC-IV). Claimant had average scores in phonemic awareness, phonemic memory, rapid naming, visual perceptual, with below-average scores in visual-motor integration. When re-evaluated in January 2007, claimant's WISC-IV

was slightly lower, with a full scale of 82-91, demonstrating low average to average cognitive abilities. She had more problems with short-term memory and slower retrieval skills. The goals for claimant's special education were to remediate her lower reading, writing, and fine motor skills.

12. Dr. Brown reevaluated claimant on March 11, 2008, due to her possible seizures and extreme behavior issues. In her report signed June 10, 2008, Dr. Brown noted it was unclear whether any of claimant's "behaviors are seizures" because no seizure activity was captured on her last video electroencephalogram (EEG) conducted in April 2007. Claimant's behavior during her "meltdowns" were described as aggressive and defiant, with hitting and kicking, and occurred every day. Claimant wanted to be left alone and had many social problems at home and at school. Claimant has many skin sensitivities/sensory issues.

On examination, Dr. Brown found claimant to be alert, pleasant, articulate and content. Her neurological examination was normal, as were her June 10, 2008 brain MRI and renal ultrasound. Dr. Brown's assessment was that, although claimant's father had a definite TS diagnosis, claimant "seems not to be demonstrating any definitive findings suggestive of the diagnosis, although her DNA testing did reveal a TSC1 DNA sequence variant of unknown significance." Further analysis of the genetic testing done on claimant's father was necessary to see if he had this particular variant. Dr. Brown found that overall claimant was functioning better on her current combination of medications. She did not require any further MRI brain scans and needed renal ultrasounds only every three years. Dr. Brown recommended follow-up gene testing and that claimant's medication regime of Lamictal, Risperdal, clonidine and trazodone continue.

In her June 10, 2008 letter to Dr. Holland, Dr. Brown mentioned that claimant had behavioral issues with the possibility of Asperger disorder; however there was no discussion of Asperger disorder in Dr. Brown's report. Dr. Brown noted that, according to her parents, claimant's seizures appear to be under good control with her current dose of Lamictal. The parents also reported that claimant's "behavior is much better since the Risperdal was added . . . her behavior is much less volatile and her moods are more stable."

13. In a March 29, 2009 letter to Dr. Holland, Dr. Brown reported that in her most recent March 6, 2009 visit, claimant "has had no interval clinical seizures and is otherwise doing well." Claimant was currently sleeping through the night. Claimant "continues to have her emotional outbursts which can be quite significant and they are random, bizarre, and do not appear to be very controllable. Social skills remain a concern and she does not seem to understand normal social cues. She continues to have a great deal of anxiety." Dr. Brown indicated that, since her last visit, claimant's parent had:

> filled out a questionnaire that indicates that [claimant] has Asperger disorder and meets the following criteria. Under social skills [claimant] appears to have difficulty in the use of nonverbal behaviors to regulate social interaction. She does not look people in the eyes, she looks away when talked to, either down or to the side. She does not

> seem to have the ability to talk back or seem put out when spoken to in a mean way. She will often answer with one word or does not seem to know what to say or how to act when conversing. She has no interest in others, and if she does interact it has to be someone that she has been around a lot. She rarely plays with other children, and has a couple of kids that she will talk to a little bit. She would rather watch or be by herself, and does not appear to want to engage with others. She does not seem to share her enjoyment, interests or achievements with others. . . She does not empathize with others, and does not understand when others are hurt. She is unable to articulate what she feels.
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> In general, she gets off topic easily and does not understand how to carry on a conversation, nor does she initiate a conversation. There is a history that [claimant] was echolalic and had delayed speech beginning at 2 years of age. She was also said to have auditory processing problems which continue…. She never had spontaneous play, nor make believe play.
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> Under unusual behavioral issues, claimant has a preoccupation with an interest that appears abnormal either in intensity or focus. . . . She also has inflexible adherence to specific nonfunctional rituals. . .
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> Actually, when one considers the fact that she has a history of speech delay and was echolalic with auditory processing, she appears to meet the criteria for high functioning autistic spectrum disorder.

Dr. Brown summarized that claimant was doing better on her current medications, but "she is having a great deal of difficulty behaviorally. Based on the DSM-IV criteria, it does appear that [claimant] meets criteria for a diagnosis of high functioning autistic spectrum disorder." She suggested a referral to ACRC for assessment of a probable diagnosis of high functioning autistic spectrum disorder.

14. *Dr. Hendren's Evaluation*: Robert Hendren, D.O., works at the University of California, San Francisco, Langley Porter Hospital & Clinics. On August 4, 2009, Dr. Hendren met with claimant and her family for 70 minutes for an evaluation. The chief complaint on evaluation was that claimant, who was then 10 years old, had probable tuberous sclerosis with "worsening of aggressive/irritable behavior and difficulty sleeping over the past year." Coinciding with puberty, claimant's behavior episodes were becoming more frequent and would last for several hours on occasion; they could happen several times a day but also cycled with greater or lesser frequency. Claimant was reported to have a history of sleep difficulty, which made her more tired during the day.

Claimant and her family reported she had difficulty in social interaction and conversation, and trouble with daily living skills (could comb her hair or brush her teeth), and that she frequently fought with her younger brother. Dr. Hendren noted that claimant's cognition, language, attention span and concentration, and memory were normal. Dr. Hendren wrote:

> [Claimant] has probable Tuberous Sclerosis and her early and sustained symptoms of poor eye contact, repetitive, stereotyped behaviors and delayed language support the diagnosis of High Functioning autism. There are several life stressors such as moving to Junior High this year and her father's long lasting back problems, which may exacerbate her irritability and impulsiveness increasing her aggressiveness. Her poor sleep is likely a major part of this irritability, however.

Dr. Hendren diagnosed claimant with autism and insomnia (Axis I); tuberous sclerosis (Axis III) and educational problems (Axis IV). Claimant was prescribed Trazedone, Melatonin and Clonidine to address her sleeping difficulties; and Risperdal for aggression/irritability, with a recommendation to switch to Abilify. She was also on Lamictal. Dr. Hendren recommended that claimant participate in a social skills group, hopefully through the regional center.

15. On December 14, 2009, claimant's triennial IEP convened through Colusa County. Speech therapist Corrine Kole conducted a speech and language evaluation for the triennial review. She determined that claimant's expressive and receptive language was within normal limits and that claimant maintained appropriate eye contact during her sessions, demonstrated appropriate pragmatic skills/language, and no longer qualified for speech and language services. Claimant was assessed by her teacher with the Behavior Assessment System for Children -2 (BASC) and scored in the average range except in "school problems," where she scored in the clinically significant range for learning problems. Her occupational therapy (OT) re-evaluation indicated deficits in fine and visual motor areas that might affect academic tasks such as handwriting. She continued to qualify for OT services. On the Woodcock-Johnson III Test of Academic Achievement, claimant's scores placed her in the "limited to average proficiency" range on broad reading, broad math, and broad written language. The IEP team summarized that:

> [claimant's] present testing findings would suggest [her] nonverbal reasoning and problem solving skills to fall within the delayed to low average range. Auditory skills reflected average range of performance on tasks tapping Phonological skills (awareness, memory, and rapid naming), auditory processing, and auditory memory skills. There was some variation on her performance on tasks tapping visual processing skills. . . Academic performance as measured by a standardized achievement test reflected low average to average skills. . .

Based on its review of new testing, the IEP team continued claimant's special education eligibility as a student with an "other health impairment." Claimant's Individualized Student Health Plan 2009-10 described a protocol to address any seizures claimant might have at school, but noted "she has not had a seizure at school for a 'very long time'."

Discussion

16. The Lanterman Act defines "developmental disability" as "a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual . . . .this term shall include mental retardation, cerebral palsy, epilepsy, autism. . . [and] disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Ins. Code, § 4512, subd. (a).) This last eligibility category is commonly referred to as the "fifth category."

17. There is no evidence of or assertion that claimant has cerebral palsy, or mental retardation.

18. In support of its determination that claimant is not eligible for regional center services, ACRC called Ms. Wheelwright, Dr. Leonard Louis Magnani, M.D., Ph.D. (Dr. L. Magnani), and staff psychologist Phyllis Sarah Magnani, Ph.D. (Dr. P. Magnani), as witnesses. Ms. G. and Ms. Vereschagin testified on claimant's behalf.

A. *Autism*

19. *Diagnostic Criteria*: The DSM-IV-TR establishes diagnostic criteria for autistic disorder and requires that the individual with this suspected condition be assessed to have a total of six items from three broad areas, with at least two from the first area, and one each from the second and third areas.

The first area considered is whether the individual has a "qualitative impairment in social interaction," as manifested by at least two of the following: (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction; (b) failure to develop peer relationships appropriate to developmental level; (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest); and/or (d) lack of social or emotional reciprocity.

The second area considered is whether the individual has "qualitative impairments in communication" manifested by at least one of the following: (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime); (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others; (c) stereotyped and repetitive use of language or idiosyncratic language; and/or (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

The third area considered is whether the individual has "restricted repetitive and stereotyped patterns of behavior, interests, and activities" manifested by at least one of the following: (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus; (b) apparently inflexible adherence to specific, nonfunctional routines or rituals; (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements); and/or (d) persistent preoccupation with parts of objects.

In addition, the individual must have experienced delays or abnormal functioning in at least one of the following areas, with onset prior to age three years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play. Finally, the disturbance "is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder."

20. *Testimony of Dr. Phyllis Magnani*: Phyllis Magnani is a Board-certified clinical psychologist who has been a staff psychologist with ACRC since 2001. For eight years before joining ACRC, Dr. P. Magnani was an associate professor at the Professional School of Psychology. She has also been a lecturer at the University of California, Davis, in the Department of Psychology and at California State University, Sacramento, in the Departments of Psychology, Education/Child Development, and Organizational Behavior and Environment. As a professor, Dr. P. Magnani taught many graduate-level classes in psychological disorders, with a special focus of autism and mental retardation in children, social-emotional development, and research.

As part of her duties with ACRC, Dr. P. Magnani is a member of the interdisciplinary eligibility team. In this context, she has assessed thousands of individuals for developmental disabilities, with the majority of her assessment on children up to 11 years old, and she has reviewed countless evaluations performed by other professionals to determine eligibility and/or the need for particular services. As part of claimant's eligibility team, Dr. P. Magnani reviewed all of the records and assessments provided. She did not directly assess claimant. Based on her review, Dr. P. Magnani concluded that claimant does not have autism as defined by the DSM-IV-TR, and is consequently not eligible for regional center services on this basis. Her testimony is paraphrased as relevant below.

21. *Autism Diagnostic Observation Schedule (ADOS) Testing*: The ADOS was developed by autism experts and is considered the "gold standard" for diagnosing autism. Any diagnosis of autism rendered without the use of the ADOS is not reliable. While the historical practice of obtaining diagnostic input from parents through interview and/or questionnaires is still helpful, the ADOS allows the assessor to directly observe the child by placing her in patterned types of social situations designed to elicit behavior that can then be evaluated in light of the diagnostic criteria. There are certain things that trained examiners must do in order to elicit these responses. The ADOS has four different modules based on a child's verbal ability. In her evaluation, Dr. Silva met with and observed claimant, reviewed claimant's records, and interviewed her mother. Dr. Silva administered the ADOS, Module III (ADOS). This was appropriate for claimant's age and developmental level. She also had Ms. G. complete the

Adaptive Behavior Assessment System, Second Edition (ABAS II), Parent Form. On the ADOS, the probability of autism increases with higher scores.

Dr. Silva determined that claimant's score on the ADOS indicated that she did not have autism. Her total communication score was 0. A score of 2 would suggest the child might fall within the autism spectrum and a score of 3 is the beginning cutoff for autism. Within this category, Dr. Silva found that claimant was highly talkative, engaged in lively conversation with the examiner, asked the examiner questions about her own life, shared her favorite activities and was able to share emotions, including feelings of anxiety. There was no immediate echolalia or repetitive speech. Claimant was able to demonstrate concern regarding whether Dr. Silva might enjoy certain movies claimant recommended. Dr. P. Magnani considered this to be indicative that claimant has "theory of mind" or the ability to understand and see from the perspective of others, which is not typical for an autistic child.

In the area of reciprocal social interaction, claimant obtained a social interaction total of 1. A score of 4 would suggest the child might fall within the autism spectrum and a score of 6 is the beginning cutoff for autism. Within this category, Dr. Silva found that claimant was friendly, open, and had a good sense of humor. She responded well to Dr. Silva, had excellent eye contact, direct facial expressions, and seemed to enjoy the one-to-one attention of an unfamiliar adult. Claimant was also slightly oppositional by dramatically complaining about having to answer questions. She was aware of the feelings her family members had about her own behaviors, but her insight into typical social relationships was slightly immature. Claimant was aware of gossip between children and said she is usually quiet at school because she was afraid she might be teased. She is usually alone at school, but has several friends. Claimant's reciprocal social communication was within age-appropriate limits.

Dr. Silva noted that claimant had no stereotyped behaviors or restricted interests. She had limited creativity in her actions and said she felt uncomfortable in make believe play. Claimant's total score on the ADOS (communication plus social interaction) was 1. A score of 7 is the autism spectrum cutoff and a score of 10 is needed for a diagnosis of autism. Claimant showed four areas of mild impairment within the DSM-IV-TR criteria for autism: in peer relationships, development of spoken language, lack of varied, spontaneous play, and preoccupation with stereotyped or restrictive patterns of interests. This was not sufficient for a diagnosis of autism.

On the ABAS-II, Ms. G. rated claimant's adaptive functioning as extremely low in the conceptual (communication, functional academics, self-direction), social (leisure, social), and practical (community use, home living, health and safety, and self-care) domains. Dr. Silva noted that claimant "struggles with significant sensory issues to sounds, textures, and clothing, which date to infancy. She struggles with a hypersensitive gag reflex as well. Because her sensory issues are so pronounced, her tolerance for frustration is low. [Claimant] exhibits emotional dysregulation and might become highly aggressive. Her moods tend to be highly variable. These behaviors are more of an issue at home, as her teachers do not note the issues with communication, socialization, and stereotyped behaviors and restricted interests to the degree that her parents observe at home." Dr. Silva "did not observe claimant to engage in any

of the restricted, repetitive or stereotyped patterns of behavior, interests or activity associated with the diagnosis of Autistic Disorder."

Dr. P. Magnani agreed with Dr. Silva's conclusion that claimant does not meet the diagnostic criteria for autism. She clarified that claimant clearly has some impairments in her social interactions; however, these impairments are not "marked" or very significant. As noted by Dr. Silva, claimant has many sensory issues that might be affecting her behaviors and ability to interact. She also noted that, after claimant has an emotional "melt-down," she will apologize to her family. This is not behavior that is seen in autistic children. Although both Dr. Hendren and Dr. Brown opined that claimant might have high functioning autism, Dr. P. Magnani testified that there is no such diagnosis. Dr. Hendren's evaluation gave this diagnosis; however, it is clear from his evaluation report that he did not administer the ADOS. His diagnosis is both incorrect and unreliable. Similarly, Dr. Brown did not administer the ADOS. Her report appears to simply summarize the responses to a parental questionnaire. None of the other records considered in this case have any information that supports a diagnosis of autism. In contrast, for example, Ms. Wheelwright's intake assessment reported similar observations to those of Dr. Silva regarding claimant's interest in conversation, her sense of humor and joint attention.

B. *Epilepsy*

22. *Testimony of Dr. Leonard Louis Magnani:* Dr. L. Magnani is a medical doctor who also holds a Ph.D. in social psychology. He was staff physician at ACRC for eight years before becoming its medical director in 2008. Dr. L. Magnani has been certified by the American Board of Family Practice since 1978. He has been an assistant clinical professor at the University of California, Davis, Medical School in the Family Practice and Psychiatry Departments. Dr. L. Magnani has been a member of ACRC's interdisciplinary eligibility team for many years, and he participated in the determination that claimant is not eligible for regional center services. In doing so, Dr. L. Magnani reviewed claimant's medical records described above as well as the clinical records of claimant's family practice physician Dr. Holland from Woodland Healthcare. Based on this review, Dr. L, Magnani concluded that claimant does not have epilepsy or epilepsy that constitutes a substantial disability for her.

23. Dr. L. Magnani testified that epilepsy is typically considered as recurrent seizures that may or may not be stopped by medications. Seizures that are not stopped by medications are known as "intractable" or "recalcitrant" seizures. Claimant's medical records indicate a history of "refractory complex partial seizures" during which, unlike grand mal seizures, full consciousness is maintained. Whether claimant actually has seizures is undetermined. Typically, seizures can be demonstrated by EEGs that measure electrical activity in the brain during a sleep study. Claimant has been reported to have intractable or recalcitrant partial complex seizures; however, these have never been confirmed despite sleep studies with continuous EEGs. There were "borderline abnormalities" in a December 2004 EEG that showed a "subtle intermittent slowing in the left temporal region during drowsiness and sleep."

This type of EEG finding is not uncommon in other people who do not have seizures. There have been no other findings. In Dr. L. Magnani's experience, it is highly unusual for a child with continuous seizures to not have any abnormal spikes on EEG/sleep studies.

Claimant has been on various medications designed to control both her seizures and her behavioral issues. Lamictal, which is the best medication for partial seizures, is also commonly used for mental health issues, such as for mood stability with bipolar disorder. Tegretol is an anti-epileptic drug that is also a mood stabilizer. Risperidone (brand name Risperdol) is an antipsychotic medication that is commonly used for mental health disorders, and is the first antipsychotic drug approved for treatment of autism. Because it is known to lower the threshold for seizures, Risperdol is typically not used for seizures. The lack of documented seizure activity despite claimant's ongoing use of Risperdol is significant. The records do not establish any documented seizure activity and more recent records indicate parent reports that seizure activity is diminished.

The suggestion that seizure activity is the cause of claimant's out-of-control behaviors is contrary to established evidence that seizures are typically sedative in nature. Dr. L. Magnani opined that claimant continued to be prescribed Tegretol more to address her ongoing behavioral issues than for any seizures. Tegretol is remarkable for helping mood disturbances, including impulsivity. Although the medical records report a history of intractable seizures/ epilepsy, one possible explanation is that claimant does not have epilepsy (therefore medications cannot cure them). Children will frequently outgrow seizures by age 10. In claimant's case, when she was much younger, Dr. Brown had considered epilepsy surgery. This surgery was never performed and, over time, was no longer mentioned as within the realm of treatment options. There were reports that claimant may have absence seizures, where the brain is frozen for a moment of time. These seizures again should be confirmed by sleep studies on EEGs showing electrical spikes. There have been no demonstrated patterns during sleep studies. There is no indication claimant still has seizures. Even if claimant has epilepsy, her seizures are not a particular problem for her because they are controlled by her current medications. Claimant's medical records describe seizure episodes as occurring when claimant is falling asleep, as indicated by claimant's arm being raised. By the time of Dr. Hendren's report, claimant had no reported seizures.

24. Assuming that claimant has epilepsy, in Dr. L. Magnani's opinion, the evidence does not demonstrate that it is a "substantially disabling condition." There are people who have epilepsy who are very functional and whose condition does not constitute a "substantial impairment" as required by the Lanterman Act; i.e., "a significant functional limitation in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: (1) Self-care; (2) Receptive and expressive language; (3) Learning; (4) Mobility; (5) Self-direction; (6) Capacity for independent living; and (7) Economic self-sufficiency." (Welf. & Ins. Code, § 4512, subd. (l).) While claimant has some weaknesses, she does not have significant functional limitations in three of the above areas that are attributable to epilepsy.

C. *Fifth Category*

25. "A person may qualify for services under the fifth category in two ways: (1) a person may have a disabling condition closely related to mental retardation; or (2) a person may have a disabling condition that requires treatment similar to that required for individuals with mental retardation. (§ 4512(a)." (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462, 1492.) "[F]ifth category eligibility depends on the similarity in the *treatment* required for an individual with a disabling condition and individuals with mental retardation. The statute does not require similarity in the educational or teaching methods." (*Id*. at 1494.) (Italics in original.)

26. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that "the fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well." (*Id*. at p. 1129.) It is therefore helpful to review the factors required for a diagnosis of mental retardation. The DSM-IV-TR provides that the "essential feature of Mental Retardation is significantly subaverage general intellectual functioning…." It must be accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below – approximately two standard deviations below the mean. It is undisputed that claimant's general intellectual functioning is not significantly subaverage.

27. *Claimant's Cognitive Functioning*: As discussed in Factual Finding 11, claimant's overall cognitive functioning when tested for special education services has typically been determined to be within the low-average to average range, with occasional scores in the moderately impaired level. Approximately one year after her 2009 triennial special education reevaluation, Dr. Silva administered the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV). Claimant's WISC-IV composite scores were in the average range (91) for processing speed, in the low-average range for verbal comprehension (89) and working memory (short-term memory) (83), and in the "extremely low" range (69) for perceptual reasoning, which measures nonverbal abilities such as spatial processing, visual motor integration, and fluid reasoning. Dr. Silva summarized that claimant:

> demonstrated significant variability between verbal and nonverbal tasks …Because of significant difference between Verbal Comprehension and Perceptual Reasoning tasks, the full scale IQ is not representative of cognitive potential which is likely largely in the Average range as measured by the verbal tasks. Processing Speed Index and Verbal Comprehension was also in the Average to Low Average range. [Claimant] achieved similar results in 2005, 2006, and 2007. The pattern of results may be indicative of a learning disorder. Adaptively, [claimant] demonstrates delays and her scores on the

> ABAS denote functioning in the Extremely Low range in all areas. Her skills appear to be highly impacted by fine motor issues. She exhibits poor self-help skills and requires assistance with basic grooming tasks. Academically, she struggles with delays, but receives special education and Resource Support.

28. Dr. Ionascu is a Clinical Neuropsychologist at Children's Hospital's Department of Neurology/Epilepsy. In her Sept 13, 2011 neuropsychological evaluation, Dr. Ionascu noted that claimant is now being home schooled. Claimant was reported to exhibit some aggression when it was time for her to go to school, and she had difficulty interacting with other children. Her parents decided to place her in independent study. Claimant currently receives services from a psychiatrist and a therapist through Colusa County Behavioral Health.

Dr. Ionascu also administered the WISC-IV to claimant with the following results. Claimant had a full scale intelligence quotient (IQ) of 78 in the moderately impaired range. She scored in the average range in working memory (91), in the low-average range in processing speed (85) and verbal comprehension (81), and in the moderately impaired range in perceptual reasoning (75). These results show there is a significant difference between claimant's verbal and her performance IQ. Academic testing with the Wechsler Individual Achievement Test, Third Edition (WIAT-3), showed:

> Reading skills in the low-average range for comprehension, while on a test of word reading [claimant's] score was average (3rd and 7th grade levels respectively). Listening comprehension for receptive vocabulary and oral discourse comprehension was average (5th and 7th grade levels respectively). Mathematics abilities were low average numerical operations (4th grade level). Math fluency was low average for addition and average for subtraction and multiplication (grade levels of 4th, 7th and 8th respectively). In regard to written language, [claimant] had an average ability to correctly respond to language prompts given to her, and low average skill in constructing original sentences (5th and 4th grade levels respectively). Oral expression was low average overall in that [claimant] had low average expressive vocabulary, and average oral word fluency and sentence repetition (3rd and 5th grade levels).

Dr. Ionascu diagnosed claimant with Encephalopathy,[3] Depression, Learning Disorders NOS, and Tuberous Sclerosis. She reported that claimant's current medications were Risperdal, Celexa, Trazodone and Melatonin. No current seizures were reported and there were no prescribed anti-seizure medications. Dr. Ionascu detailed recommendations for claimant that

[3] There was no explanation of this diagnosis. Dr. L. Magnani opined that, in light of claimant's depression, this diagnosis may refer to something pathologic with the way the higher brain functions. Dr. Ionascu may also have used the term in the context of TS.

included continuation of speech and occupational therapy; social skills training; academic accommodations; and counseling for depression and involvement in pro-social peer-oriented activities, particularly if she is continued in home school.

29. Claimant's test results from her most recent evaluation by Dr. Ionascu are largely consistent with those previously conducted as described above. As indicated in the testimony of both Dr. P. Magnani and Dr. L. Magnani, the Lanterman Act excludes eligibility based upon learning disorders. Claimant's global cognitive function is reflective of learning disorders and is not closely related to mental retardation. Dr. Ionascu's treatment recommendations described above are not similar to those required by individuals with mental retardation. While claimant would definitely benefit from services, she does not require treatment that is similar to that required for individuals with mental retardation.

30. *Tuberous Sclerosis*: Dr. L. Magnani testified that it is very rare not to find tissue evidence of tuberous sclerosis by the time a child is eight or nine years old. It is confirmed by the presence of two genetic markers. While claimant has had several skin lesions which may suggest TS, these lesions are not diagnostic. Claimant's June 10, 2008 MRI/brain scan showed no abnormal tissue present, no evidence of any masses, even with a high resolution scan. A renal study showed normal kidneys, even though children with TS typically have kidney tumors by this age. Dr. Brown's June 10, 2008 report concluded that claimant "seems to not be demonstrating any definitive findings suggestive of this diagnosis…" Based on the medical records, Dr. L. Magnani opined that, despite her paternal history, there is a likelihood that claimant does not have TS. Dr. L. Magnani agreed with Ms. G. that genetic markers for TS are not present in 20 percent of the cases and that it is possible claimant can have TS which can appear at a later time due to variants of this disease.

Dr. L. Magnani described his philosophy on determining eligibility as one that includes all children who come within the legal definition of developmental disability. It is very difficult to deny services to children who could benefit from services, but who do not meet the legal requirements for eligibility. There are individuals who have confirmed diagnosis of tuberous sclerosis, but who have not yet experienced brain tumors that affect their cognition or behavior. He agreed that it is possible that claimant will develop tuberous sclerosis later in life and that tumors in the brain could impact her cognitive functioning. According to Dr. L. Magnani, if claimant develops TS before the age of 18 and it is a substantially disabling condition, she should reapply for regional center services.

31. Claimant's mother testified that claimant has deficits and needs help. In her experience, it is very hard to secure help for a child, especially if the child –like her daughter— has potential. The situation is particularly difficult during economic hard times for schools and counties. In her opinion, claimant definitely has clinically significant issues. For example, she will run into the street, forgetting to be cautious; she cannot wash or brush her own hair or tie her shoes; and she lacks fine motor skills. Claimant's situation is frustrating because she needs and deserves help. Ms. G. wants her daughter to have the ability to function and to be independent some day. Claimant has a probable diagnosis of TS; she may develop brain tumors in the future like her father.

Ms. G. has seen the effect of seizures on claimant, who will "sleep it off" and become irritable and not function. The family weaned claimant off seizure medication because the seizures happened at night and the medications caused side effects that made her like a "walking zombie" during the day.

Regarding Dr. L. Magnani's testimony that there has been no EEG confirmation of seizures, Ms. G. testified that the family decided to stop these tests because they require claimant to be "knocked out" for each MRI/sleep study and there was an increased risk she would not wake up. As a result, the family has chosen to concentrate on behavior therapies to teach claimant tools to make her a better person. The family hoped for regional center services to help claimant because, unlike a really cognitively impaired person, she is able to learn and benefit from them. Ms. G. fought for years to obtain special education services and was not concerned about the "other health impaired" eligibility label (as opposed to autism, for example) selected by the IEP team. She just wanted services for her daughter.

32. Eva Vereschagin is completing her internship for a Masters in Family Counseling while working with Colusa County Behavioral Health. She provides family wrap around services every one to two weeks to claimant and her family. Ms. Vereschagin has observed claimant's tantrum behaviors, and noted that they include some that demonstrate inappropriate impulse control. For example, at her IEP, claimant began to crawl under the table; she then realized this was inappropriate and got back up. Ms. Vereschagin agreed that claimant's condition and behaviors are hard to categorize.

LEGAL CONCLUSIONS

1. The Lanterman Act does not assign the burden of proof to either party, and no appellate court has decided this issue. Typically, the burden of proof is on the individual seeking rights or services. Consistent with this principle and in the absence of any applicable statute under the Lanterman Act, the burden of proof is on claimant to prove, by a preponderance of the evidence, that she has a developmental disability that originated prior to age 18 that constitutes a substantial disability for her. (Welf. & Ins. Code, § 4512, subd. (a); Evid. Code, §§ 500, 115.)

2. Developmental disability is defined by Section 4512, subdivision (a), of the Lanterman Act as "a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature."

Developmental Disability shall not include handicapping conditions that are solely psychiatric disorders, solely learning disabilities; or solely physical in nature. (Cal. Code Regs. tit. 17, § 54000, subd. (c).)

3. A "substantial disability" means "the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: (1) Self-care; (2) Receptive and expressive language; (3) Learning; (4) Mobility; (5) Self-direction; (6) Capacity for independent living; and (7) Economic self-sufficiency." (Welf. & Ins. Code, § 4512, subd. (l).) The regulations clarify that substantial disability means "a condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential. . ." (Cal. Code Regs. tit. 17, § 54001, subd. (a)(1).)

4. As set forth Factual Finding 17, there is no evidence or contention that claimant has cerebral palsy or mental retardation.

5. As set forth in the Factual Findings and Legal Conclusions as a whole, and particularly in Factual Findings 19 through 21, the evidence does not support a finding that claimant has autism.

6. As set forth in the Factual Findings and Legal Conclusions as a whole, and particularly in Factual Findings 22 through 24, while claimant has a consistent history of reported seizures, the weight of the evidence does not support a finding that she currently has epilepsy or has seizures that constitute a substantial disability for her.

7. As set forth in the Factual Findings and Legal Conclusions as a whole, and particularly in Factual Findings 25 through 30, the evidence does not support a finding that claimant has a condition that is either closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation, based upon her cognitive testing and/or diagnosis of probable tuberous sclerosis.

8. Claimant did not establish that she has a developmental disability under the Lanterman Act that qualifies her for regional center services with ACRC.

ORDER

Claimant's appeal of ACRC's decision that she is not eligible for regional center services under the Lanterman Act is DENIED.

DATED: December 15, 2011

_____
MARILYN A. WOOLLARD
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of this decision. (Welf. & Inst. Code, § 4712.5, subd.(a).)